DIZZINESS QUESTIONNAIRE

1. In your own words, please describe your dizziness or the sensation you are experiencing:

_____

_____

2. When did you experience your first symptom? _____
3. When did you experience your last symptom? _____
4. Have you experienced dizziness in the past? Yes No
   If so, when? _____
5. Describe what will:
   make your symptoms less severe: _____
   make your symptoms more severe: _____
6. Are your symptoms associated with: (i.e. occurring at the same time, beginning, or after)
   fasting or eating? Yes No
   a cold or other infection? Yes No
   a head injury or other accident? Yes No
   a headache? Yes No
7. Do you have migraine headaches? Yes No
8. Are you taking any medications for your symptoms? Yes No
   If so, please list: _____
9. Were you exposed to any irritating gases or fumes at the onset of your symptoms? Yes No
   If so, please list: _____

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Please circle the best answer:

1. My dizziness is constant, all day long. Yes No
2. My dizziness comes and goes, fluctuates. Yes No
3. My dizziness lasts: SECONDS MINUTES HOURS DAYS OTHER _____
4. I feel like I am spinning or moving. Yes No
5. I feel like I am still, but my surroundings are moving. Yes No
6. My dizziness makes me nauseous or sick feeling. Yes No
7. My dizziness has caused me to vomit. Yes No
8. My dizziness causes the environment to move or bounce when I run or walk. Yes No
9. I become dizzy when:
   things around me move or pass by. Yes No
   I am sitting still in a chair. Yes No
   I am exposed to bright lights. Yes No
   I hear loud sounds or noises. Yes No

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Do you have any of the following symptoms:

double vision? Yes No
spots before your eyes? Yes No
difficulty swallowing? Yes No
difficulty with speech? Yes No
blurred vision? Yes No
blindness? Yes No
numbness in your face, arms, or legs? Yes No
clumsiness in arms or legs? Yes No
confusion? Yes No
change in taste or smell? Yes No

Please circle the best answer to the best of your knowledge:

1. Do you have:
   - difficulty hearing? Yes No
     - * if yes, which ear? Right Left Both
     - * which ear is worse? Right Left Neither
   - ear pain? Yes No
     - * if yes, which ear? Right Left Both
   - drainage from your ears? Yes No
     - * if yes, which ear? Right Left Both
   - pressure or fullness in your ears? Yes No
   - noises in your ears? Yes No
     - * if yes, which ear? Right Left Both
     - * do the noises change when you are dizzy? Yes No
     - Please describe the noises you experience: _____
2. Does your hearing change, come and go? Yes No
   If yes, please describe: _____
3. Do you feel that your hearing loss is related to your symptoms of dizziness? Yes No
   If yes, please explain: _____

Please circle the best answer.

1. Do you experience:
   - * lightheadedness? Yes No
   - * sensation that you are going to black out? Yes No
   - * blackouts? Yes No
   - * loss of consciousness? Yes No
   - * falling to the right? Yes No
   - * falling to the left? Yes No
   - * falling forward? Yes No
   - * falling backward? Yes No
2. Do any of the following actions make you dizzy?
   - * turning over in bed? Yes No
   - * getting out of bed? Yes No
   - * looking up? Yes No
   - * standing quickly? Yes No
   - * walking? Yes No
   - * standing or walking in the dark? Yes No
   - * standing or walking on uneven surfaces? Yes No
   - * riding in a car? Yes No

If other changes in position or movements make you dizzy, please describe them: _____

_____

If you have any questions, please do not hesitate to call one of our audiologists.